

Title: **Basic UBO Billing - CMS 1500**

Session: **T-1-1330**



# Objectives

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- Understand the data elements necessary for claim submission
- Know which data elements are required and which are situational
- Understand how elements link together to give the total picture of what happened during the patient encounter

# 1500 Claim Form

PICA																							
<div style="display: flex; justify-content: space-between;"> <div> 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>  <small>(Medicare #) (Medicaid #) (Tricare/Champus/Spouse's SSN) (Member ID) (SSN or ID) (ILLING SSN) (ID)</small> </div> <div> 1a. INSURED'S I.D. NUMBER <span style="float: right;">(For Program in Item 1)</span> </div> </div>																							
<div style="display: flex;"> <div style="flex: 1;"> 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)   5. PATIENT'S ADDRESS (No., Street)   CITY <span style="float: right;">STATE</span>   ZIP CODE <span style="float: right;">TELEPHONE (Include Area Code)</span>  ( ) ( ) </div> <div style="flex: 1;"> 3. PATIENT'S BIRTH DATE <span style="float: right;">SEX</span>  MM DD YY <span style="float: right;">M F</span>   6. PATIENT RELATIONSHIP TO INSURED  Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>   8. PATIENT STATUS  Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>  Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> </div> <div style="flex: 1;"> 4. INSURED'S NAME (Last Name, First Name, Middle Initial)   7. INSURED'S ADDRESS (No., Street)   CITY <span style="float: right;">STATE</span>   ZIP CODE <span style="float: right;">TELEPHONE (Include Area Code)</span>  ( ) ( ) </div> </div>																							
<div style="display: flex;"> <div style="flex: 1;"> 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)   a. OTHER INSURED'S POLICY OR GROUP NUMBER   b. OTHER INSURED'S DATE OF BIRTH <span style="float: right;">SEX</span>  MM DD YY <span style="float: right;">M F</span>   c. EMPLOYER'S NAME OR SCHOOL NAME   d. INSURANCE PLAN NAME OR PROGRAM NAME </div> <div style="flex: 1;"> 10. IS PATIENT'S CONDITION RELATED TO:   a. EMPLOYMENT? (Current or Previous)  <input type="checkbox"/> YES <input type="checkbox"/> NO  b. AUTO ACCIDENT? <span style="float: right;">PLACE (State)</span>  <input type="checkbox"/> YES <input type="checkbox"/> NO  c. OTHER ACCIDENT?  <input type="checkbox"/> YES <input type="checkbox"/> NO  10d. RESERVED FOR LOCAL USE </div> <div style="flex: 1;"> 11. INSURED'S POLICY GROUP OR FECA NUMBER   a. INSURED'S DATE OF BIRTH <span style="float: right;">SEX</span>  MM DD YY <span style="float: right;">M F</span>   b. EMPLOYER'S NAME OR SCHOOL NAME   c. INSURANCE PLAN NAME OR PROGRAM NAME </div> </div>																							
<p style="text-align: center;"><b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b></p> 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED: _____ DATE: _____																							
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED: _____																							
<div style="display: flex;"> <div style="flex: 1;"> 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)  MM DD YY   17. NAME OF REFERRING PROVIDER OR OTHER SOURCE   17a. _____  17b. NPI: _____ </div> <div style="flex: 1;"> 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE  MM DD YY   18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  FROM MM DD YY TO MM DD YY   20. OUTSIDE LAB? <span style="float: right;">\$ CHARGES</span>  <input type="checkbox"/> YES <input type="checkbox"/> NO </div> <div style="flex: 1;"> 16. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  FROM MM DD YY TO MM DD YY   21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24c by Use)  1. _____ 3. _____   2. _____ 4. _____ </div> </div>																							
<div style="display: flex;"> <div style="flex: 1;"> 24. A. DATE(S) OF SERVICE  From MM DD YY To MM DD YY  B. PLACE OF SERVICE  C. EMG  D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)  CPT/HCPCS   MODIFIER  E. DIAGNOSIS POINTER  F. \$ CHARGES  G. DTS  H. SPEC  I. ID QUAL  J. RENDERING PROVIDER ID # </div> <div style="flex: 1;"> 25. MEDICARD RESUBMISSION CODE  ORIGINAL REF. NO.   29. PRIOR AUTHORIZATION NUMBER </div> </div>																							
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">25. FEDERAL TAX I.D. NUMBER</td> <td style="width: 10%;">SSN EIN</td> <td style="width: 10%;">26. PATIENT'S ACCOUNT NO.</td> <td style="width: 10%;">27. ACCEPT ASSIGNMENT?</td> <td style="width: 10%;">28. TOTAL CHARGE</td> <td style="width: 10%;">29. AMOUNT PAID</td> <td style="width: 10%;">30. BALANCE DUE</td> </tr> <tr> <td></td> <td></td> <td></td> <td>YES <input type="checkbox"/> NO <input type="checkbox"/></td> <td>\$</td> <td>\$</td> <td>\$</td> </tr> </table>										25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE				YES <input type="checkbox"/> NO <input type="checkbox"/>	\$	\$	\$
25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE																	
			YES <input type="checkbox"/> NO <input type="checkbox"/>	\$	\$	\$																	
<div style="display: flex;"> <div style="flex: 1;"> 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS  (I certify that the statements on the reverse apply to this bill and are made a part thereof.)   SIGNED: _____ DATE: _____ </div> <div style="flex: 1;"> 32. SERVICE FACILITY LOCATION INFORMATION   a. _____ b. _____ </div> <div style="flex: 1;"> 33. BILLING PROVIDER INFO &amp; PH # ( )   a. _____ b. _____ </div> </div>																							



# 1500 Claim Form

1500				HEALTH INSURANCE CLAIM FORM				Patient Registration			
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 0605								PICA <input type="checkbox"/>			
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input checked="" type="checkbox"/> (ID)				1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000000000							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Joe P				3. PATIENT'S BIRTH DATE MM DD YY 00 00 00				4. INSURED'S NAME (Last Name, First Name, Middle Initial) Smith, Joe P			
5. PATIENT'S ADDRESS (No., Street) 1234 Plain Street CITY Anytown STATE IA				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 1234 Plain Street CITY Anytown STATE IA			
ZIP CODE 23456 TELEPHONE (Include Area Code) (333) 333-3333				8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				ZIP CODE 23456 TELEPHONE (Include Area Code) (333) 333-3333			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER GR0101010			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. INSURED'S DATE OF BIRTH MM DD YY 00 00 00				SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. EMPLOYER'S NAME OR SCHOOL NAME Main Street Employer				c. INSURANCE PLAN NAME OR PROGRAM NAME National Insurance			
c. EMPLOYER'S NAME OR SCHOOL NAME				10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete Item 9 and.			
d. INSURANCE PLAN NAME OR PROGRAM NAME				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim or for the payment of benefits either to myself or to the party who accepts assignment.				SIGNED Signature On File DATE 06/06/06				SIGNED Signature On File			



# 1500 Claim Form

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**Items are automatically populated by TPOCS**

**Item 1: Required**

Type of Health Insurance Coverage

Insurance coverage. System defaults to “Other”

**Item 1a: Required**

Insured's ID Number

Insured's social security number

**Item 2: Required**

Patient's Name (Last Name, First Name, Middle Initial)

Patient's last name, first name, and middle initial

**Item 3: Required**

Patient Birth date

Eight-digit birth date (MM|DD|CCYY) of the patient



# 1500 Claim Form

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## **Item 3: Required**

Patient's Sex

Patient's sex

## **Item 4: Required**

Insured's Name (Last Name, First Name, Middle Initial)

Insured's last name, first name, and middle initial

## **Item 5: Required**

Patient's Address

Mailing address and telephone number of the patient in the corresponding boxes



# 1500 Claim Form

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## **Item 6: Required**

Patient's Relationship to Insured

Relationship of the patient listed in Item 2 to insured listed in Item 4

## **Item 7: Required, if applicable**

Insured's Address

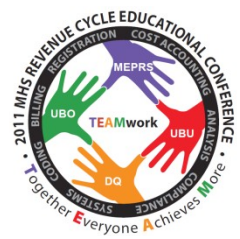
Mailing address and telephone number of the insured in the corresponding box. If Item 4 is completed, then this field should be completed

## **Item 8: Required**

Patient Status

Marital status and full- or part-time student.

NOTE: Patient Status does not exist in the electronic 837 Professional 41010A1



# 1500 Claim Form

## **Item 9: Required, if applicable**

Other Insured's Name

If the 'Yes' is checked in Item 11D,  
then this section (Items 9-9D) must be filled out.

Name of the insured person (last, first, middle initial)

## **Item 9a: Required, if applicable**

Other Insured's Policy or Group Number

Other insured's insurance policy or group number





# 1500 Claim Form

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## **Item 9b: Required, if applicable**

Other Insured's Date of Birth/Sex

Eight-digit date of birth (MM|DD|CCYY). Check the appropriate box

indicating the sex of this person

## **Item 9c: Required, if applicable**

Employer's Name or School Name

Employer's name or school name of the other insured person.

NOTE: Employer's Name or School Name do not exist in the electronic 837 Professional 41010A1

## **Item 9d: Required, if applicable**

Insurance Plan Name or Program Name

Name of the insurance plan or program related to the other insured person



# 1500 Claim Form

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## **Item 10a-10c: Required, if applicable**

Is Patient's Condition Related To: (Auto Accident/Other Accident)  
Check the appropriate box if the patient's condition is related to any  
of the following: employment (MAC), auto accident, or other accident

## **Item 10d: Not Required**

Reserved For Local Use  
Leave blank

## **Item 11: Conditional**

Insured's Policy Group or FECA Number  
Insured's policy group or FECA number

## **Item 11a: Required**

Insured's Date of Birth/Sex  
Eight-digit date of birth (MM|DD|CCYY); check the appropriate box indicating the sex of the insured



# 1500 Claim Form

## **Item 11b: Conditional**

Employer's Name or School Name

Employer's name or school name of the insured.

NOTE: Employer's Name or School Name do not exist in the electronic 837 Professional 41010A1

## **Item 11c: Required**

Insurance Plan Name or Program Name

Name of the insurance plan or program of the insured

## **Item 11d: Required, if applicable**

Is There Another Health Plan Benefit?

If 'Yes' is checked, Items 9-9d must be completed.

Check the appropriate box to indicate whether or not there is another health insurance benefit. System defaults to "No"



# 1500 Claim Form

## **Item 12: Required with a default (“Signature on file” is acceptable)**

Patient’s or Authorized Persons Signature

This item is automatically populated with the following statement,

“Assignment of Benefits is assumed under 10 U.S.C. 1095”

## **Item 13: Required with a default (“Signature on file” is acceptable)**

Insured’s Authorized Person’s Signature

This item is automatically populated with the following statement,

“Assignment of Benefits is assumed under Title 10 U.S.C. 1095” and

with “Signature on file”

## **Item 14: Required, if applicable**

Date of Current Illness, Injury, or Pregnancy

Current date of illness, injury or pregnancy (MM|DD|CCYY)



# 1500 Claim Form

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## **Item 15: Required, if applicable**

If Patient Has Had Same or Similar Illness

Past occurrence date (MM|DD|CCYY) of illness or injury  
if it is the same or similar illness or injury

## **Item 16: Not Required**

Dates Patient Unable to Work in Current Occupation  
Leave blank

## **Item 17: Conditional (Revised- Title was changed from Referring Physician to Referring Provider)**

Name of Referring Provider or Other Source

Name of the provider who referred or ordered the service



# 1500 Claim Form

## **Item 17a: Conditional (Revised-This area was shaded and a new field was added to hold the two-digit qualifier for other ID Number)**

The Other ID Number of Referring or Ordering Provider, Qualifier

The Provider Taxonomy code of the referring provider or ordering

provider should be reported in the shaded area. The qualifier (**PX- Provider Taxonomy**) identifies the type of Other ID being reported in the shaded area

## **Item 17b: Required, if applicable**

Provider NPI #

NPI Type1 of the referring or ordering provider will appear in this field, if available. If NPI is missing, then the Current Provider ID and/or Tax ID will be reported in Item 17a until the NPI is provided

## **Item 18: Required, if applicable**



# 1500 Claim Form

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## **Item Number 17, 17a, and 17b (split field)**

### **17: Name of Referring Provider or Other Service**

TPOCS will populate the referring provider information in Items 17, 17a and/or 17b

### **17a: Other ID#**

Current Provider ID and/or Tax ID will be used until the NPI # is used.

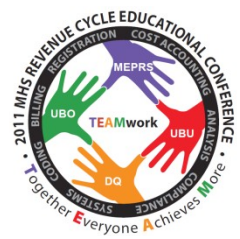
Once NPI is implemented, the primary HIPAA taxonomy code associated

with the provider specialty table will be reported for the referring provider,

ordering or other source and will populate from TPOCS

### **17b: NPI**

The NPI number of the referring provider will populate from TPOCS



# 1500 Claim Form

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## **Item 19: Not Required**

Reserved for Local Use

Leave blank

## **Item 20: Not Required**

Outside Lab

Leave blank

## **Item 21: Required**

Diagnosis or Nature of Illness or Injury

ICD-9-CM diagnosis code for the patient's diagnosis/condition.

The ICD-9-CM diagnosis code must be coded to the highest specificity and sequenced in order of priority (e.g., primary or secondary condition)

## **Item 22: Not Required**

Medicaid Resubmission

Leave blank





# 1500 Claim Form

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## **Item 23: Required, if applicable**

Prior Authorization Number

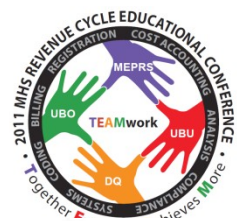
Prior authorization number for those procedures requiring prior authorization

## **Section 24 (Revised—To accommodate submission of both the NPI and other Provider Identifier during the NPI transition)**

### **Item 24a: Required**

Dates of Service

Eight-digit date (MM|DD|CCYY) of the time period in which the services were performed



# 1500 Claim Form

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
MM DD YY		MM DD YY		FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>James A. Physician, MD</b>				17a. 24 0123456789	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
				17b. NPI 0123456789	FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)				22. MEDICAID RESUBMISSION CODE	
1. V58.11				ORIGINAL REF. NO.	
2. 186.9				23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE		C. PLACE OF SERVICE		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
From MM DD YY To MM DD YY		E. DIAGNOSIS POINTER		F. \$ CHARGES	
10 23 06 10 23 06 11		99213 25		1,2,3,4 85.00 1	
10 23 06 10 23 06 11		96413		1,2 290.00 1	
10 23 06 10 23 06 11		96415		1,2 65.00 1	
10 23 06 10 23 06 11		96417		1,2 141.00 1	
10 23 06 10 23 06 11		J9206		1,2 105.00 5	
10 23 06 10 23 06 11		J9201		1,2 2169.00 9	
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT?	
444444444		101010		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
\$ 4155.00		\$		\$ 4155.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					
John Doe, MD					
32. SERVICE FACILITY LOCATION INFORMATION					
Office Place 1001 Medical Rd Anytown IA 12345					
33. BILLING PROVIDER INFO & PH #					
Office Place Provider PO Box 11111 Anytown IA 12345					
SIGNED		DATE		a. 9876543210 b. N5288888	
102306				a. 9876543210 b. B3288888	



# 1500 Claim Form

## **Item 24b: Required**

Place of Service

Code "26" represents an MTF. This code should automatically print on all CMS-1500s. However for an emergency room visit, the place of service will be coded as "23" Emergency Room. TPOCS will provide the biller the option to determine if the encounter is related to ER services. When saving the bill TPOCS will assign the place of service based on MEPRS code BIA\* and default to "Y" (yes) for Item 24c -EMG

## **Item 24c: Required, if applicable (Revised-This was originally titled**

**"Type of Service." This field is now titled "EMG")**

EMG

EMG represents Emergency Indicator. The indicator states whether or not a service(s) is related to an emergency. If MEPRS code is BIA\* and services are emergency related, then Y for "Yes" will appear in the box or if "No" the field will be left blank



# 1500 Claim Form

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## **Item 24d: Required**

Procedures, Services, or Supplies

HCP/CS/CPT code, including modifiers when applicable, for the

procedures, services, or supplies furnished to the patient

## **Item 24e: Required (Revised-Title changed from Diagnosis Code to Diagnosis Pointer)**

Diagnosis Pointer

Pointer number (1-4) from Item 21 that is applicable to that specific procedure, service, or supply furnished

## **Item 24f: Required**

Charges

Charge for each listed service.



# 1500 Claim Form

## **Item 24g: Required**

Days or Units

Number of days or units that were supplied for that particular HCPCS/CPT code listed in that line. If only one service was provided, the numeral 1 must be entered. This field will default to 1

## **Item 24h: Not Required**

EPSDT Family Plan

Leave blank

**Item 24i: Required (Revised-This field was originally titled "EMG," which is now in Item 24c. This field is now titled "ID Qualifier")**

ID Qualifier

The ID qualifier will default to (**PX- Provider Taxonomy**) and will be used to report the type of non-NPI number of the rendering provider. The Provider Taxonomy code of the rendering provider will be reported in the shaded area of Item



# 1500 Claim Form

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**Item 24j: Required (Revised-This field was originally title "COB.")**

**The original fields 24j and 24k were combined and renumbered and now titled "Rendering Provider ID#")**

Rendering Provider ID#

The Provider Taxonomy code of the rendering provider will be reported in the shaded area. NPI Type 1 of the rendering provider will be reported in the unshaded area.

**Item 24k: This field was deleted and combined with 24j.**  
Deleted

**Item 25: Required**  
Federal Tax ID Number



# 1500 Claim Form

## **Item 26: Required**

Patient's Account Number

Patient's account number that is assigned by the MTF's accounting system to identify that particular patient

## **Item 27: Required**

Accept Assignment

TPOCS defaults to "X" in the 'Yes' box, indicating assignment of benefits is accepted pursuant to Title 10 U.S.C. 1095

## **Item 28: Required**

Total Charge

Total charges for the services provided (e.g., sum of charges in Item 24F)

## **Item 29: Conditional**

Amount Paid

\$0.00 indicates no up-front monies were paid. DoD does not collect

co-payments for services rendered





# 1500 Claim Form

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## **Item 30: Conditional**

Balance Due

Total amount of the charges. This should match Item 28

## **Item 31: Required**

Signature of Physician or Supplier

Signature of the provider of service or supplier, or his representative, and the date the form was signed. A signature or stamp is required here. Some MTFs use this area to indicate who, the biller was and that the bill has been reviewed

## **Item 32: Required-Treating Service Facility**

Name and Address of Facility Where Services Were Rendered

Name, address, and telephone number of the MTF

## **Item 32a: Required (New field)**

NPI #

NPI Type 2 of the treating MTF will be reported in this field





# 1500 Claim Form

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## **Item 32b: Required (New field)**

Other ID Qualifier and Other ID#

The qualifier will be reported followed by the HIPAA  
Taxonomy code or Treating Facility Tax ID

## **Item 33: Required- Billing Provider Information**

Physician, Supplier Billing Name, Address, Zip Code, Phone,  
PIN#, and Group#

Name of the physician who rendered the services. It is now  
required that the provider be identified with their credentials  
(e.g., MD, NP, PA, RN, LPN). The system should include the  
provider's credentials following the name



# 1500 Claim Form

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## **Item 33a: Required (New field)**

NPI #

NPI Type 2 of the billing facility will be reported

## **Item 33b: Required (New field)**

Other ID#

The qualifier followed by the HIPAA Taxonomy or Billing Facility Tax ID will be reported



# Summary

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1. We have reviewed the data elements necessary for claims submission
2. We know why these are required
3. And which ones are required on the form or are situational



# Questions

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- Thank you for attending this session and learning about how to fill out the professional CMS 1500 claim form
- Any questions?